TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

FORM C-44

220 French Landing Drive, Ste. 1-B, Nashville, TN 37243-1002
Telephone: (615) 532-1309 or (615) 253-1606 Facsimile: (615) 253-5266
Send fax or email to ATTN: Administrative Review Email address: WC.Info@tn.gov

THIS FORM MUST BE RECEIVED WITHIN 7 <u>CALENDAR</u> DAYS OF RECEIPT OF SPECIALIST'S ORDER.

<u>Request for Administrative Review of a Workers' Compensation Specialist's Order</u>

Review Requested by:

_____ Employee
_____ Employee's Attorney
_____ Employer
_____ Employer's Attorney
_____ WC Insurance Carrier
_____ WC Insurance Carrier's Attorney

Printed Name of Employee _____
Social Security Number of Employee _____
State File Number _____
Date of Injury _____
Printed Name of Employee's Attorney (if known):
_____

Printed Name of Employer _____
Printed Name of Claims Adjuster _____
Printed Name of Employer's/Carrier's Attorney (if known):
_____

Date Order Issued _____ Date Order Received by Requesting Party _____
Name of WC Specialist Issuing Order _____
City Where Issuing Specialist Works _____

Order to be Reviewed is an: _____ Order for Benefits _____ Order of Denial

Specifically, what aspect(s) of the decision made by the Workers' Compensation Specialist do you disagree with? For what reason(s)? **(Must attach and timely supplement any and all documentation which supports your position.)** Attach as many additional sheets as necessary. _____

Teleconferences must be scheduled within ten (10) calendar days of the receipt of this request form by the Administrative Review office. **Please list your availability for the next ten days** (Please list the **time zone** for which the times are given):

_____

Person within your office to contact regarding the scheduling of this matter: _____

By my signature below, I hereby certify that I have (1.) provided notice by telephone AND (2.) provided a true and correct copy of this Request for Administrative Review of a Workers' Compensation Specialist's Order and all supporting documentation and information attached hereto to the opposing party and/or counsel for the opposing party by facsimile, e-mail, and/or regular mail.

_____ _____
PRINTED NAME OF REQUESTING PARTY **PHONE (INCL. AREA CODE)**

_____ _____
SIGNATURE OF REQUESTING PARTY **DATE**

_____ _____
EMAIL ADDRESS OF REQUESTING PARTY **FAX**

Printed Address of Requesting Party:

Company/Firm Name (if applicable): _____
Street Address: _____
City, State and Zip Code: _____

<u>*A Copy of Workers' Compensation Specialist's Order to be reviewed must be attached.***</u>**